

PCP (Phencyclidine)

PCP (phencyclidine) was developed in the 1950s as an intravenous anesthetic. Its use in humans was discontinued in 1965, because patients often became agitated, delusional, and irrational while recovering from its anesthetic effects. PCP is illegally manufactured in laboratories and is sold on the street by such names as *angel dust*, *ozone*, *wack*, and *rocket fuel*. *Killer joints* and *crystal supergrass* are names that refer to PCP combined with marijuana. The variety of street names for PCP reflects its bizarre and volatile effects.

PCP is a white crystalline powder that is readily soluble in water or alcohol. It has a distinctive bitter chemical taste. PCP can be mixed easily with dyes and turns up on the illicit drug market in a variety of tablets, capsules, and colored powders. It is normally used in one of three ways: snorted, smoked, or ingested. For smoking, PCP is often applied to a leafy material such as mint, parsley, oregano, or marijuana.

Health Hazards —————

PCP is addictive—its repeated use can lead to craving and compulsive PCP-seeking behavior. First introduced as a street drug in the 1960s, PCP quickly gained a

reputation as a drug that could cause bad reactions and was not worth the risk. After using PCP once, many people will not knowingly use it again. Others attribute their continued use to feelings of strength, power, invulnerability, and a numbing effect on the mind.

Many PCP users are brought to emergency rooms because of PCP overdose or because of the drug's unpleasant psychological effects. In a hospital or detention setting, these people often become violent or suicidal and are very dangerous to themselves and others. They should be kept in a calm setting and not be left alone.

At low to moderate doses, physiological effects of PCP include a slight increase in breathing rate and a pronounced rise in blood pressure and pulse rate. Breathing becomes shallow, and flushing and profuse sweating occur. Generalized numbness of the extremities and loss of muscular coordination also may occur.

At high doses of PCP, blood pressure, pulse rate, and respiration drop. This may be accompanied by nausea, vomiting, blurred vision, flicking up and down of the eyes, drooling, loss of balance, and dizziness. High doses of PCP can also

cause seizures, coma, and death (though death more often results from accidental injury or suicide during PCP intoxication). High doses can cause symptoms that mimic schizophrenia, such as delusions, hallucinations, paranoia, disordered thinking, a sensation of distance from one's environment, and catatonia. Speech is often sparse and garbled.

People who use PCP for long periods report memory loss, difficulties with speech and thinking, depression, and weight loss. These symptoms can persist up to a year after stopping PCP use. Mood disorders also have been reported. PCP has sedative effects, and interactions with other central nervous system depressants, such as alcohol and benzodiazepines, can lead to coma.

Extent of Use —————

2004 Monitoring the Future (MTF) Survey*

MTF data show that in 2004, 1.6 percent of high school seniors reported lifetime** use of PCP; annual use was reported by 0.7 percent of seniors, and 30-day use was reported by 0.4 percent. Data on PCP use by 8th- and 10th-graders are not available.

2002 Drug Abuse Warning Network (DAWN)***

PCP mentions in emergency departments increased 28 percent from 1995 to 2002. There was a 42 percent increase from the 5,404 mentions in 2000 to 7,648 in 2002. There were significant increases in PCP mentions in Washington DC, Newark, Philadelphia, Baltimore, and Dallas. Chicago had a decrease in mentions of PCP, declining 48 percent from 874 in 2001 to 459 in 2002.

2003 National Survey on Drug Use and Health (NSDUH)****

According to the 2003 NSDUH, 3.0 percent of the population aged 12 and older have used PCP at least once. Lifetime use of PCP was highest among those aged 35 or older (3.6 percent), compared with people 26 or older (3.3 percent), 18 to 25 (3.0 percent) and those aged 12 to 17 (0.8 percent).

Rates of lifetime use among 12- or 13-year-olds decreased significantly from 2002 to 2003. Past month use decreased among 14- or 15-year-olds, but increased among 16- or 17-year-olds.

* These data are from the 2004 Monitoring the Future Survey, funded by the National Institute on Drug Abuse, National Institutes of Health, DHHS, and conducted by the University of Michigan's Institute for Social Research. The survey has tracked 12th-graders' illicit drug use and related attitudes since 1975; in 1991, 8th- and 10th-graders were added to the study. The latest data are online at www.drugabuse.gov.

** "Lifetime" refers to use at least once during a respondent's lifetime. "Annual" refers to use at least once during the year preceding an individual's response to the survey. "30-day" refers to use at least once during the 30 days preceding an individual's response to the survey.

*** The latest data on drug abuse-related hospital emergency department (ED) visits are from the 2002 DAWN report, from HHS's Substance Abuse and Mental Health Services Administration. These data are from a national probability survey of 437 hospital EDs in 21 metropolitan areas in the U.S. during the year. For detailed information from DAWN, visit www.samhsa.gov/statistics/statistics.html, or call the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686.

**** The 2003 NSDUH, produced by HHS's Substance Abuse and Mental Health Services Administration, creates a new baseline for future national drug use trends. The survey is based on interviews with 67,784 respondents who were interviewed in their homes. The interviews represent 98 percent of the U.S. population age 12 and older. Not included in the survey are persons in the active military, in prisons, or other institutionalized populations, or who are homeless. Findings from the 2003 National Survey on Drug Use and Health are available online at www.DrugAbuseStatistics.samhsa.gov.